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CIA HISTORICAL STAFF

The Support Services Historical Series

OVERVIEW OF THE OFFICE OF MEDICAL SERVICES 1947-1972

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OMS-6

February 1973

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THE SUPPORT SERVICES HISTORICAL SERIES

OMS-6

OVERVIEW OF THE OFFICE OF MEDICAL SERVICES 1947-1972

25X1 *by*

[redacted]

February 1973

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[redacted]

John R. Tietjen, M.D.
Director of Medical Services

HISTORICAL STAFF
CENTRAL INTELLIGENCE AGENCY

SECRET

Foreword

The purpose of this volume of the history of the Office of Medical Services is to provide an overview of the activities of the office from 1947 to 1972. This is one of six volumes devoted to the Agency's medical programs; the other five describe the specific programs of the Field Support Staff, the Operations Division, the Psychiatric Staff, the Clinical Division, and the Psychological Services Staff.

This volume was written by [redacted] 25X1 who has been with the office since 1952 and is now (September 1972) Executive Officer.

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OVERVIEW OF THE OFFICE OF MEDICAL SERVICES
1947 - 1972

I. Inheritance, 1945-47

A. OSS Forebears

The Office of Medical Services of the Central Intelligence Agency may be unique in the Western World and perhaps in the entire world. It is not, however, unprecedented. There was a Medical Services Office in the Office of Strategic Services (OSS) at the time of its discontinuance in October 1945, and thereafter the medical office was attached to the Strategic Services Unit (SSU) of the War Department and then to the Central Intelligence Group (CIG) when it was established by President Truman in January 1946.

A history of the OSS Medical Services Office 1/* describes its evolution -- in response to exigencies

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* For serially numbered source references, see Appendix F.

rather than planning -- over a two-year period, from 1942 to 1944. In May 1942 the author of the history, 25X1 [redacted] a Captain in the Army Medical Corps at the time, was assigned to one of the OSS outlying detachments in the Washington area. Undoubtedly because OSS Headquarters on E Street had no other available medical resources, [redacted] was called 25X1 upon with increasing frequency for assistance. In March 1943 this tendency resulted in his assignment as "Chief Surgeon" to the headquarters Services Branch, 25X1 under [redacted], for the purpose of operating a Headquarters Dispensary. This dispensary amounted to two small rooms on the second floor of the [redacted] 25X1 25X1 Building.* [redacted] was to be responsible for sick call, examinations for civilians going overseas, and administration of an OSS medical service. By now promoted to Major, he was given two Army enlisted men to assist in the dispensary. This dispensary

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* See Figure 1, p. 3

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was what the CIA medical service inherited.

The account of the evolution of the OSS medical service mentioned developments that were later to be remarkably similar to those in the evolution of the CIA medical service -- its emergence as a separate office not under administrative services or the personnel office, the tendency for operating branches to plan or act without appropriate medical coordination, the need for secure handling of covert civilians who are ill or injured, and the efforts toward accommodation between a medical service and a psychological assessment service that were organizationally separate.

B. The Garage

When the OSS medical service phased through the Strategic Services Unit to the Central Intelligence Group, personnel changed, of course, but in 1946 they remained essentially military. In November of that year, First Lieutenant John R. Tietjen, MC, reported for duty as a staff medical officer after completion of a military training course at Brooke Army Medical Center at Fort Sam Houston, Texas. Thus

the physician who was to head the CIA medical service for a quarter of a century, and whose personal career is almost synonymous with the growth and development of that service, came on stage.

At that time [redacted] was the Chief Surgeon of the Medical Office, which was part of the CIG Personnel Division. He, Dr. Tietjen, some 13 Army enlisted technicians, and three civilian nurses staffed the Medical Office. Tietjen directed the activities of the dispensary, which -- although still over the Garage -- had expanded to take over the entire second floor, a total now of six rooms. There were also two health rooms in other buildings. In 1947 the CIG medical program involved entrance-on-duty and overseas physical examinations -- 2,600 of both types in that year -- immunizations, sick call in which there were some 11,800 out-patient visits, and a growing interest in medical intelligence, particularly epidemiology.2/ 25X1

Following the activation of the Central Intelligence Agency in September 1947, plans were accelerated for the conversion of the Medical Office to

civilian staffing. The original intent was to use US Public Health Service (USPHS) medical officers for this. This was a time, however, when the number of physicians available to the USPHS, as with the military services, was decreasing, and USPHS medical officers were not available to the new CIA.

In January 1948, Tietjen, still a military officer but by then a Captain, succeeded [redacted] as Chief of the Medical Office. In May of the following year, when he was separated from the Army, Dr. Tietjen continued in this position as a civilian. He was then in the position he was to hold without interruption for almost a quarter of a century.

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II. Getting Things Started, 1947-50

A. The Founding Fathers

In the late 1940's the Medical Division, as it was then called, was part of the Personnel Office -- it was not to attain independent status until 1950 -- and was made up of some dozen employees, two of whom were medical officers. Two of the employees who were present at the creation remain with the OMS to this day (1972) -- Dr. Tietjen himself and [redacted] 25X1

25X1 [redacted] who was then a staff nurse and is now the Chief Nurse.

B. Military to Civilian

The Medical Division was a small and not unconventional Government medical unit in an era -- between World War II and the Korean War that was to come -- that seems quiet and uneventful in retrospect. This is not to say that there were no challenging problems in connection with the establishment and development of a new civilian medical unit. Much effort went into the development of standards for

selection, which were based essentially on those of the Civil Service Commission, and for overseas assignment. The Division was also concerned with the opening of Agency health rooms -- by then there were 12 of these, the compilation and specification of immunization requirements, and the initiation of an acceptable and confidential system for the maintenance of medical records. Not the least of the accomplishments of this period was, of course, that by early 1948 the medical component had become a truly civilian one.3/

C. Early Overseas Interests

Involvement with planning for overseas medical support began in 1948 with the [redacted] 25X1 and the Office of Special Operations (OSO). It was also in 1948 that [redacted] 25X1 was detailed to the Agency for a special assignment in the Far East. Pending the negotiations for this assignment, [redacted] served 25X1

in the Medical Division for more than a year.* He was of great assistance in developing and presenting some of the initial courses in first aid and in the design of the early medical kits for Agency use.**

D. Move to a Larger Facility

By the spring of 1948 the medical unit had outgrown the Garage, and the nursing element moved to the first floor of the west wing of Central Building. In late 1948 the rest of the medical unit -- office, pharmacy, X-ray, laboratory, and examination elements -- followed. The CIA Medical Office was then in the building where it was to remain until the move into the Langley Headquarters in 1962.

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With the passage of the Central Intelligence Agency Act in June 1949, CIA medicine received its first statutory authority for its overseas activities. This was to provide the necessary foundation for the later development of the overseas medical program. Headquarters medical service had been, and still is, provided essentially under the authority of Public Law 658 of 1946 and subsequent amendments and executive orders.*

The year 1949 was also a milestone for another reason. In October the Personnel Director approved the request of the Chief of the Medical Division for the establishment of a medical consultant service.4/ This action was a major advance in developing the

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* PL 79-658 authorized Federal departments and agencies to establish employee health service programs limited to emergency treatment of on-the-job illnesses and dental conditions, pre-employment and other physical examinations, and preventive medical programs. The law required that employees be referred to private physicians and dentists for all other-than-emergency treatment. Public Law 110 of 1949, the so-called Central Intelligence Act, contained authorization for Agency medical services not authorized by PL 658. For a discussion of the authorizations in PL 110, see HS Project No. 5.037, The CIA Clinical Medicine Program, 1947 - 1965, S.

professional potential of the CIA medical element. One of the first medical consultants was Dr. [redacted] 25X1

25X1 [redacted] who was of great assistance in securing the services of many of the consultants who followed.*

It was also in 1949 that formal coordination between the CIA medical unit and the US Public Health Service and the Bureau of Employees' Compensation was established.

E. The First Doctor Hired

25X1 [redacted] was the first full-time doctor hired by CIA as such. In March 1950 he left private practice in Washington, D. C. to become the second civilian medical officer in the Agency. [redacted] 25X1

25X1 [redacted] experience as a flight surgeon with the Army Air Corps in World War II was to stand him in

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25X1 * [redacted] both just out of residency training, earlier in 1949 became the first "When-Actually-Employed" (WAE) Examiners for the Medical Division. In this capacity, working on a scheduled basis in the division, they were in effect part-time employees. WAE medical officers are still an important part of OMS professional capabilities.

good stead, as he was given responsibility for the Medical Division's liaison with the Office of Policy Coordination (OPC). In June 1950, on the eve of the Korean War, this liaison relationship developed into [redacted] appointment as Medical Representative on OPC, Staff II, for the purpose of establishing operational medical support. This was added to his primary assignment as Deputy to Dr. Tietjen. It was also in June 1950 that the Medical Division became the Medical Staff, reporting directly to the CIA Executive.

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During 1950 medical support planning for the [redacted] accelerated. In January 1951 this resulted in the assignment of [redacted] was the first medical technician assigned overseas.

25X1

25X1

25X1

III. The Korean War, 1950-53

A. The Great Expansion

Within a month of the invasion of South Korea by the Communists (25 June 1950) requests for operational support from the elements of OPC were pouring in to the harried OPC Medical Representative, 25X1 [redacted] These requests were generally for medical assistance in planning and executing paramilitary activities in the Far East. This in turn involved specifics such as medical kits, aid stations and even hospitals, medical personnel requirements, medical training, and medical aspects of other Agency activities in support of the US efforts as part of the United Nations mission.5/ The demands were such that in August 1950 it was necessary to establish a new and separate division in the Medical Staff to handle them. In addition to his other 25X1 duties, [redacted] headed this Special Support Division, as it was called.6/ The pace of Agency activities increased suddenly and appreciably in other parts of the world as well as in the Far East. Somewhat

similar requests -- but of less magnitude -- were coming in, for example, from Europe and the Middle East. These involved kits, other medical supplies, and in some instances medical training.7/ The small Medical Staff was to be sorely tried during the next two years. It rose to the occasion, however, and responded in a manner that in retrospect gives pride to those who were involved.

The major urgent problem areas that confronted the Chief of the Medical Staff in 1950 were:

Personnel -- the procurement of medical officers and medical technicians required for suddenly expanded activities and new Agency activities.

Training -- the training and orientation of these individuals and the provision of elementary medical training for certain Agency lay personnel.

Management -- the development of an enlarged Agency medical organization and the management of it.

B. Recruitment

In mid-1950 there were not enough physicians for the civilian economy of the US, and the US Armed Forces entered the Korean War woefully short of medical officers. The crisis was so acute that Congress, in response to the urgent recommendation of the

President, did an unprecedented thing: in September 1950 it passed a law drafting for two years of military service one special class of citizen -- physicians.8/ This unheard-of step was the only way the Armed Forces could fill thousands of vacancies for medical officers in the expanding military establishment. This was the situation that confronted the Chief of the Medical Staff when his job was to hire physicians for the Agency. The Agency's solution to this problem was to solicit the assistance of the Department of Defense. With the approval of Anna Rosenberg, the Assistant Secretary of Defense for Manpower -- the first, and thus far, the only woman to hold such a position, an arrangement was made whereby physicians who had been commissioned and were about to be ordered to active military duty would be interviewed by a CIA recruiter. If they were interested and acceptable to the Agency, their active-duty orders would be revoked. After CIA clearance they would enter on duty as full-time contract medical officers for two years. Upon completion of this service, and upon certification by

CIA, the physicians' military files in The Pentagon would be annotated to indicate that they had served for two years as civilian medical officers for CIA and should not be ordered to active duty by the military.*

This was the way CIA provided itself with medical officers during the great expansion of the Korean War. A consultant physician was employed for this recruitment -- [redacted] of Washington, D. C., who was later to become famous as the originator and director of [redacted] spent

25X1

25X1

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* This was the arrangement that came to be known unofficially as the "equivalent service" agreement. The military files of a score of physicians who served with CIA from 1951 to 1953 were accordingly documented. In the latter year it was discontinued when a complication developed. The agreement was with DOD and not with the Selective Service System. It was adequate for any physician who had at any previous time been inducted into military service by Selective Service -- even as a medical student. It was not, so it was learned, adequate for any physician who had never been inducted. The latter was subject to induction in the General Draft as well as the Doctors' Draft; it was a "double jeopardy" case, and civilian service with CIA did not satisfy the obligation to the Selective Service. Only actual military service would satisfy that.

much time traveling to various parts of the country to interview prospective physicians, and his effectiveness in this effort was largely responsible for the success of this recruitment effort.*

Staff recruiters from the Office of Personnel made similar trips to recruit the medical technicians needed for the Agency expansion. There was no civilian shortage in this type of personnel; indeed the military veterans from World War II provided a ready source for such recruitment, and many fine former military medics were recruited. Many of these remain with the Agency to this day (1972) -- they have had distinguished careers and have risen to positions of considerable responsibility.

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[redacted] who is now with the Agency's Office of Research and Development, was one of the first physicians recruited in this effort. He came aboard in January 1951 and was assigned to

25X1

[redacted] in March of that year. [redacted]

25X1

25X1

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*[redacted] is not related to the author of this history.

who now holds a senior administrative position in the Office of Medical Services (OMS), was one of the first medical technicians recruited in the great expansion. He entered on duty in January and in May 1951 became the first medical technician assigned to

25X1 [redacted]

In all, some [redacted] 25X1 technicians were recruited for Agency employment in the accelerated recruitment efforts of 1950-52. Some of these were assigned to the Headquarters Medical Staff, which was expanding as described below. Most of them, however, were assigned to the newly created medical positions overseas. Early overseas assignees in this group were the following, assigned in 1951:

Medical Officers

25X1 [redacted]

Medical Technicians

25X1

[redacted]

C. Training

The Korean War led to a tremendous acceleration of all Agency training activities. One of the primary purposes of the first foreign temporary-duty (TDY) trip by an Agency medical officer -- in August 1950 -- was to survey the site on [redacted] for a

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25X1

[redacted]

[redacted] 25X1

For new medical officers the presumption was made -- with the justification that they were just out of internship or residency training -- that no professional training by the Agency Medical Staff was required. They required orientation in Agency management and administration, and perhaps in certain technical procedures; but after these were taken care of they were ready for their Agency assignments.

Not so with the new medical technicians. Many of these men had been out of the medical field since their World War II military service and required refresher training in laboratory, X-ray, and clinical procedures. In September 1951, to provide this type of training, the Medical Staff established its own school in the [redacted] 25X1 temporary structure on Independence Avenue. Medical officers served as instructors and gave technicians a highly concentrated but comprehensive review prior to field assignment. A major thrust of this training was medical support for the paramilitary operations

being projected by OPC. An interesting and important subsidiary effort of this school was the preparation of medical manuals for the use of medical and lay personnel in field assignments.

As the Agency Office of Training developed new courses in response to OPC requirements, there were demands on the Medical Staff for speakers and demonstrators to present the medical sections of the courses -- first aid, personal health maintenance, and field sanitation. There were also increasing requirements for briefings and tutorials for individual non-medical employees being assigned to the field, as the Agency deployed additional personnel throughout the world -- some to posts devoid of any provisions for US-type medical care.10/

Medical technician personnel were also selected as cadres for new Agency training installations in

25X1

[redacted]

By February 1951 training demands on the Medical Staff required the establishment of a separate

Program Coordination Division, as described below, to coordinate medical training and related activities.11/

D. Organizational Growth and Management

The Technical Services Division (TSD) was a recognized organizational entity within the CIA medical element from as far back as 1946. This was essentially the clinical, laboratory, pharmacy, and X-ray activity. Dr. Tietjen himself operated this activity, with the assistance of part-time consultants

25X1

[redacted]

proliferating demands from OPC required more of his time than did his duties as DC/MS. In March 1951

25X1

[redacted] made the second overseas medical survey, this time to Europe. In August and September 1951 he made another but more extensive survey of Agency installations in the Far East. It was also in the summer of 1951 that a clearer definition of the organizational relationship of OPC to the parent CIA resulted, incidentally, in [redacted] more formal designation as Medical Advisor to OPC, attached to the Office of the Chief of the Administrative and Logistical Staff of OPC.12/ 25X1

It was becoming increasingly clear that the growing demands from OPC elements for medical support could not be satisfied by any traditional medical advisory relationship. The demands now involved large quantities of medical supplies and equipment as well as medical personnel. In January 1952, the Chief of the Medical Staff (C/MS) formally recommended to the Deputy Director for Administration (DDA) that

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[redacted]

25X1

[redacted]

One other significant development in field support in 1952 might be recorded. This was the approval that the Chief of the Medical Staff obtained in April of that year for a privileged means of communication between medical officers in the field and in headquarters. This was the RYBAT MEDICAL communication system whereby cables and dispatches concerning the medical diagnosis and treatment of individuals would be seen only by the medical officers concerned.* This was an important advance in the proper handling of privileged personal information. Approval for this arrangement did not come easily; certain operational individuals resisted long and tenaciously what they considered to be a concession to medicine. The Chief of the Medical Staff was

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* It was understood, of course, that the medical officer would inform the Chief of Station of any command or administrative implications of such cables and dispatches.

able, however, with the assistance of the DDA, to convince the appropriate senior officials of the Clandestine Services of the wisdom of the arrangement.14/ The RYBAT MEDICAL system remains in effect to this day and has clearly justified itself on many occasions in providing an effective means for the exchange of clinical information between Agency medical officers.

Throughout 1950 and well into 1951 the Special Support Division itself handled all matters pertaining to OPC medical support, including the recruitment and training of new medical personnel. With the merger of OPC and the Office of Special Operations (OSO) in early 1952 demands [redacted] increased even more. 25X1

Even before this merger the need for a larger support structure in the Medical Staff had become pressing, and in February 1951 the Program Coordination Division (PCD) had been established. In March 1951 [redacted] was appointed the first chief of PCD; and his staff consisted of four medical officers, one non-physician training officer, 25X1

and secretarial personnel. Major missions of the division were training and research, and, as part of the training mission, a school for medical technicians was established in September 1951. In addition to this type of training and training in first aid and field sanitation for lay employees, the division also provided special training in medical aspects of survival for staff and agent personnel being prepared for special assignments.*

Much of the division's research was done in response to requests from overseas medical officers.

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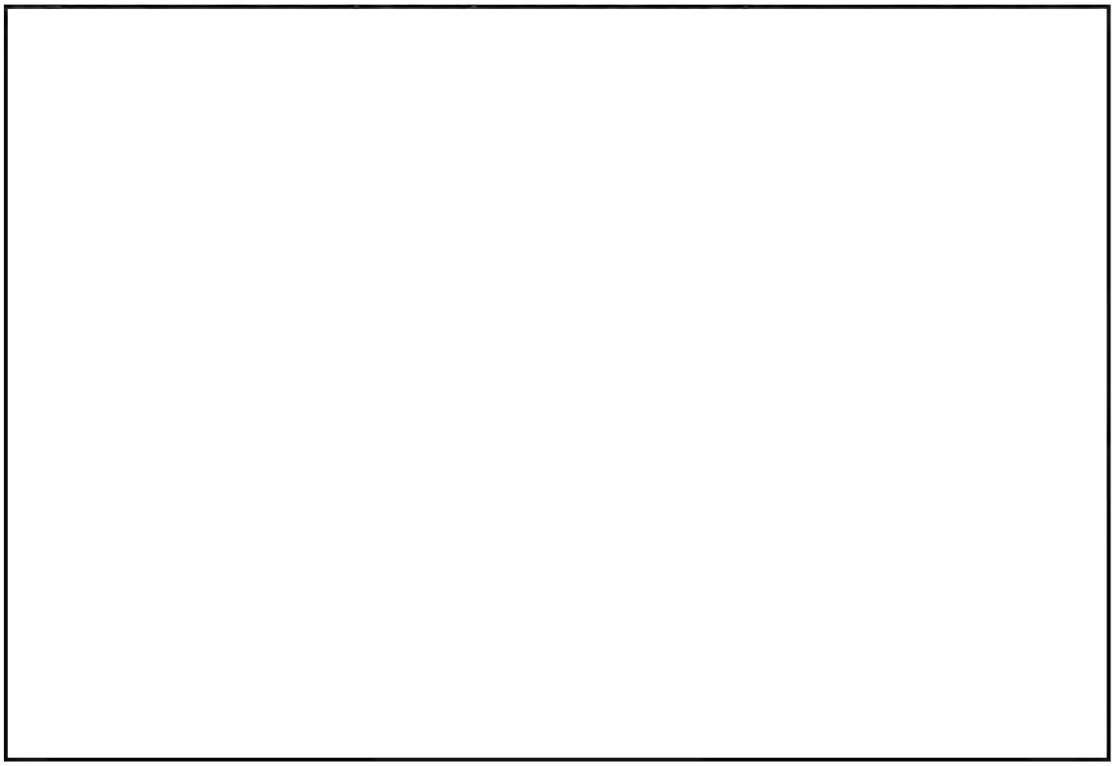

25X1 [redacted]

25X1 [redacted] In 1952, PCD research efforts were greatly facilitated by the establishment of a medical library as a division of the Agency library but in the PCD/MS area. A librarian was also provided. These were the resources that permitted the Medical Staff to produce the medical manuals for use in the field.

In August 1951, to relieve the existing divisions of personnel administration, finance, and medical supply chores, the Administrative Services Division (ASD) was established, with [redacted] 25X1 as its chief. The change-over of responsibilities was gradual; it was not until 1953, for example, that ASD assumed total Medical Staff responsibility for the recruitment and administration of medical personnel for field assignment and for the adminis-

tration of the field medical supply system.* Up to that time the Special Support Division under [redacted] 25X1

25X1 [redacted] had directed those activities as part of its general responsibility for the field medical program.

Since 1946 the Chief of the Medical Staff had become increasingly convinced of the need for a psychiatric service as the increasing complexity of Agency operations surfaced problems of mental illness. The major expansion during the Korean War made the need even more acute. Dr. Tietjen's conviction was shared by the DDA and by the DCI

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* It was as part of this planned development of the Administrative Services Division that two administrative officers joined the CIA Medical Staff upon separation from military service as Army Medical Service Corps Officers. These were

25X1 [redacted] who joined in December 1952 as Chief, Administrative Services Division, and

25X1 [redacted] who joined in March 1953 as Chief of the Supply Branch of that division.

himself.*

In July 1952, as a result of this concern, the Psychiatric Division was established. [redacted] 25X1 who had served the Medical Staff as its 25X1 psychiatric consultant since 1951, was the moving force behind the plan to establish a psychiatric unit.** It was he who, at the request of Tietjen, had studied the need for a psychiatric input to the Agency's medical selection techniques; the report of his lengthy investigation was submitted in February 1952.16/ It was also [redacted] 25X1 who recruited the first Agency psychiatrist, [redacted] 25X1 who, at the 25X1 request of the Agency, was detailed and entered on

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* One more item might be added to the legendary accounts concerning General Walter B. Smith. By way of lending his endorsement to the establishment of an Agency psychiatric selection program, Smith informed the Chief of the Medical Staff that he wanted a program that would "keep the fuzzy-heads out."

** [redacted] 25X1 is still an OMS consultant. In 1969 25X1 the DCI recognized [redacted] long and distinguished service to CIA by a congratulatory letter, which was an unprecedented gesture for medical consultant service.

duty in July 1952.

The psychiatric program was planned for development in phases, and the plan provided for the use of psychiatry in Agency selection activities, clinical psychiatry under certain stipulations, consultation, education, research, and advisory assistance to operating officials.

A second staff psychiatrist and a clinical psychologist were added to the division in 1953. Growth steadily increased with the expansion of division requirements. By 1956 there were six psychiatrists and two clinical psychologists on full-time duty in the division. The division's staff of consulting psychiatrists and psychologists had also been greatly expanded.

Initial successes of the Psychiatric Division outside of the Medical Staff were with the Office of Security for professional assistance in selection

25X1

[redacted] 25X1

Thus by 1952 the Medical Staff consisted of 25X9 [redacted] staff employees. One other management milestone of this period should also be recorded. By mid-1952 there was in being within the staff a "Personnel Policy Board" for the consideration of personnel matters involving its own medical personnel. Made up of the Chief and other senior officials of the Medical Staff, it was clearly a forerunner of

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* The then-DDI, Robert Amory, had mentioned to the Chief of the Medical Staff that he "hoped that the Intelligence Directorate would not be overlooked in the Agency's psychiatric program." This triggered discussion with the DDI in which it was agreed that three experimental groups, each led by a professional psychiatrist, would be established for the purpose of identifying and understanding some of the behavioral influences of importance in the DDI area. Although the groups met for more than a year, after reviewing the effort the Chief of the Medical Staff decided that he did not have sufficient substance for a report to the DDI on the matter of "DDI dynamics." Two follow-on groups continued until 1960-61, but the effort was eventually discontinued.

the Medical Career Board that was to be established with the formation of Agency career services in 1953.

IV. The Cold War, 1953-60

A. Medical Support to the Outer Bastions

The new year of 1953 brought a new national administration with a new foreign policy. This came to be closely identified with the new Secretary of State, whose brother became the new Director of Central Intelligence in February 1953. Henceforth, "massive retaliation" and "containment" were to be key policies that were greatly to affect the Agency's course. Containment involved the development of bastions in far-flung areas, and the Agency was called on for support. Medical support was in turn requested from the Agency Medical Office -- which it again came to be called in early 1953. [redacted] 25X1

25X1 [redacted]

25X1 [redacted] In early 1954, NSC 5412 formalized the Agency's role in many of these new efforts and charted its course for the next several years.

The direction and support of the new medical field installations required frequent overseas TDY trips by senior Medical Office officials. Starting with the initial circumnavigation by the Chief of the Medical Office in February 1953, there was to be an average of one overseas trip every six months. In addition to Dr. Tietjen, the Deputy Chief and the division chiefs made such survey trips. These trips had the beneficial effect of keeping field medical personnel in touch with the headquarters Medical Office developments and of enabling headquarters to respond more knowledgably to emergent field problems.

In January 1956, Tietjen was asked to designate

[redacted] 25X1

of the Medical Office, was so designated, and the office was thus brought into the U-2 project.18/ Medical responsibilities for the project were assumed jointly by the Medical Office and the Air Force, with a specified division of functions. The Medical Office became responsible for the emotional and personality

evaluations of pilot candidates and for the continuing care of Agency personnel assigned to the project.

B. Maturation

As with most of the Agency, the Medical Office was started and directed by young men. These men, cast into positions of senior responsibility without the years of training and experience that prepare senior officials in most other organizations, undoubtedly experienced problems -- some self-generated, perhaps -- that older hands would have avoided. Yet this very youth and inexperience made for a certain élan and aggressiveness that were appropriate for the new and unprecedented tasks they faced.

During the 1950's, the Medical Office weekly staff meetings -- "Medical Office Advisory Staff Meetings," as they were called -- were lively affairs with a noticeable lack of unanimity. There was also no small amount of divisional rivalry. This was most evident in the Psychiatric Division; and other divisions, perhaps understandably, tended to resist

what they considered the higher priorities accorded the activities of the Psychiatric Division.

If the early 1950's was a period of accelerated growth for the Medical Office, the mid and late 1950's was a period of maturation -- a time for catching up and refining some of the hastily developed procedures and approaches adopted at the time of the Korean War expansion. Some of the areas in which this maturation was evident in the 1950's follow:

1. Professional Programs. The psychiatric program did unquestionably receive special attention and encouragement. It was born on the first day of FY 1953, and its growth and development were conspicuous for the remainder of the decade.19/ This growth was both in quantity and quality. By 1957, for example, of the six staff psychiatrists in the Psychiatric Division, five were board-certified in this specialty. Efforts were also made to extend the psychiatric attitude to other office officials. Both the Chief and the Deputy Chief of the Medical

Staff,* for example, made visits to the Mecca of psychiatry -- the Menninger Clinic in Topeka -- as part of this effort to expand the psychiatric awareness of staff officials. June 1954 was a milestone for the Psychiatric Division; approval was granted by the DDA for the division's use of the Personal Index, the individual test battery that was to provide the basis for the volume screening necessary

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* The Medical Office was redesignated the Medical Staff on 11 March 1955.

Poliomyelitis was a major Agency clinical problem before the advent of the Salk vaccine in the mid-1950's. This crippling disease was a hazard for agencies engaged in overseas activities, and the Agency was not untouched. Competition for the limited amount of vaccine that became available in 1955 was intense throughout the US. The Agency was successful in obtaining quantities for its overseas assignees and their dependents, and by the end of that year inoculations were routine for these groups. A major health threat to Agency overseas activities was thus removed almost at one stroke, thanks to this great advance of modern medicine.

In 1954 the Medical Office's Zone of Interior (ZI) Consultant Program was established. This provided contractual agreements between the Agency and

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purpose of these regional medical conferences was to reduce the "psychological distance" between headquarters and field medical personnel. Headquarters representatives returned with more insight into field problems, and field personnel were left with a better understanding of the "whys" behind some of the headquarters decisions. The result of this improved understanding was presumably a more efficient field medical program.

The desirability of providing medical evaluations for dependents prior to overseas movement with Agency employees had been recognized and discussed for many years,* and in 1958 with the assistance of the DDS and the DDP, the Medical Staff's proposed program for such evaluations was approved; and the additional resources required -- personnel, funds, and space -- were forthcoming.22/ The program was initiated on 10 April 1958, and it developed on a phased basis, examinations for returning dependents being added in

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* Inoculations for these dependents had always been provided.

1960.

3. Other Signs of Maturation. Much of 1954 and 1955 was taken up with planning the medical space requirements for the new Headquarters Building. Even after these were submitted in final form, there were space changes and improvements to be considered for the existing Medical Office facilities, which were spread out in [redacted] 25X1 [redacted] 25X1 For example, in 1956 the Medical Staff Registrar's Office, which had been established in 1954 as the central repository for the storage of medical clinical records and for the handling of medical administrative matters, installed an ingenious "dumb waiter" to transmit medical charts from the chart room on the second floor to the Registrar's office itself on the first floor of [redacted] 25X1 It was also a significant improvement when the filing of charts in this same chart room was converted from the cumbersome four-drawer cabinets to an open-shelf system in 1958.

It was also during the 1950's that the staff of the office began to derive whatever satisfaction

comes from having other Government agencies seek advice -- the National Security Agency, which was just then starting its medical program, was especially interested in the experiences of the Agency Medical Staff. The 1950's will also be remembered for the several surveys of and inquiries into Agency activities by Presidential groups. In 1955 it was the Hoover Commission, and in 1957 it was the Killian Committee -- General Cassidy of the latter met with each division and staff chief of the Medical Staff in the course of the survey.

In 1955 the Medical Office underwent its first full-scale routine survey by the Inspector General.

[redacted]

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C. Career Personnel

The procurement of medical officers in the early 1950's was based largely on the Agency's "equivalent service" agreement with the Department of Defense whereby the physician, as a military reserve officer,

could satisfy his two years of obligatory military service under the Doctors Draft Law by serving as a civilian medical officer in CIA.* This arrangement was necessary because of the scarcity of physicians, many of whom were in the military services. Such medical officers were obviously not careerists with the Agency. When this arrangement was discontinued in 1953, there were but five career medical officers with the Agency. As the non-careerist medical officers left the Agency after their typical two years of service, it became necessary to resort to active-duty military and Public Health Service (PHS) officers to replace them. At the Agency's request these officers would be assigned to the Agency and would serve -- not in uniform -- in any assignment, headquarters or field, as determined by the Chief of the Medical Office. These officers served with great distinction; some of them served in senior positions, and a few of them made lasting contributions to the Agency medical program. They, too, however, were

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* See p.15, above.

not careerists and were not the appropriate types on which to build a career medical program. This was clearly enunciated in the program announced by the Chief of the Medical Office in September 1954, which called for the intensification of efforts to recruit civilian and potential career medical officers rather than to rely on the military and PHS.

One of the first medical officers to be recruited under this new effort was [redacted] 25X1

25X1 [redacted] a physician who had enjoyed a distinguished career as a wartime military medical officer and who was then engaged in industrial medicine. Dr.

25X1 [redacted] entered on duty in June 1955 as Chief of the Program Coordination Division. He enjoyed another distinguished career as an Agency medical officer, making a unique contribution to the intelligence

[redacted] 25X1

25X1 [redacted] became Deputy Director of Medical Services in 1969 and retired in 1971 with the Distinguished Intelligence Medal. The citation for this award

25X1 stated that [redacted]

> made a unique and lasting contribution in placing the skills and insights of professional

medicine at the disposal of the Agency. In founding what is in effect a separate [redacted] he has provided unparalleled precedent for his successors of the manner in which great specialized competence and dedication may be devoted to the service of the Nation.24/ 25X1 25X1

The goal of an all-civilian corps of medical officers with career potential was attained by the end of the decade. This was achieved despite the continuing disadvantage of a GS salary schedule that had not yet become even reasonably competitive with salaries in industrial and private medicine.

D. Career Development

Beginning in 1954 there were expanded efforts toward establishing a staff of career medical officers, and of course there were many discussions about how this might be best achieved. The consensus of these considerations was recorded in a paper written by the Chief of the Medical Office in January 1955, "Policies Relating to Employment and Career With the Medical Office." This paper set the

pattern for the ensuing years.*

The paper recognized the desirability of continuing professional development and recommended, among other things, Agency-sponsored extended professional training for career medical officers. Approval of the DDA would be necessary in each case.

25X1 [redacted] was one of the first careerists trained under this program. In 1955, following completion of his overseas tour as Senior Far East Medical Representative, he entered one-year residency training in internal medicine in Chicago. Nine career medical officers have had this type of extended Agency-sponsored training, and there is clear evidence that the program has been a wise investment for insuring the Agency's continuing medical professional competence.**

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* The paper was issued -- after approval by the DDA -- as MO Regulation 7-55, 30 December 1954, Policies Relating to Employment and Career with the Medical Office.

** Seven of these nine medical officers have remained with the Agency.

25X1

[redacted] was also the first medical officer to participate in another expansion of career development for Agency medical officers. On completion of his residency training in 1956, he was assigned to the Office of Scientific Intelligence of the Intelligence Directorate. This, the result of an agreement between the Director of Scientific Intelligence and the Chief of the Medical Staff, opened a continuing rotational assignment opportunity for Agency medical officers.

V. Three Active Years, 1960-62

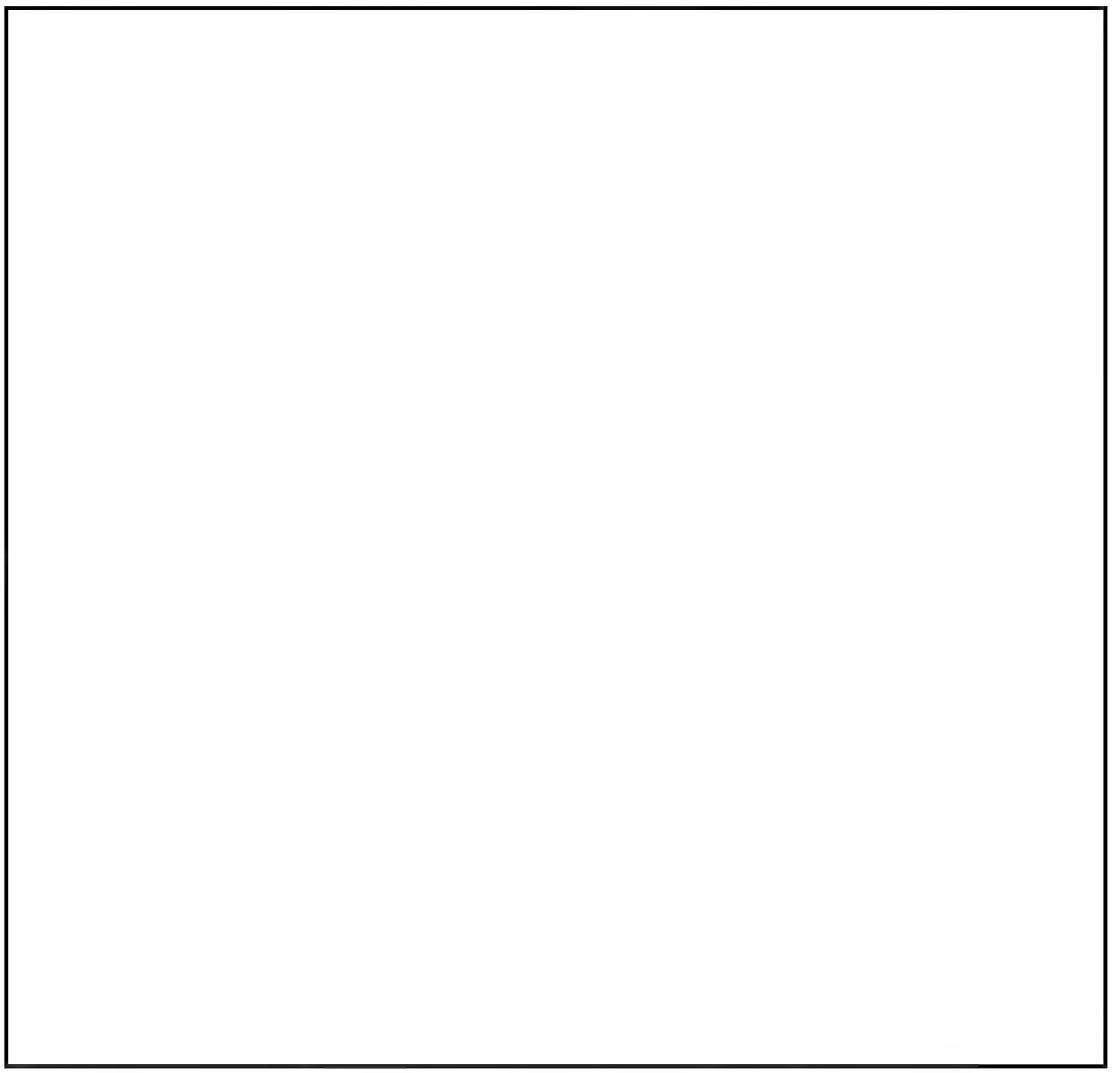
A. The Cuban Operation

On 17 March 1960 President Eisenhower directed CIA to undertake the military training of Cuban nationals striving to establish a democratic government in Castro-dominated Cuba. From that date through the actual military operation of April 1961, and well into the phasing-down of 1963, [redacted] 25X1

[redacted] 25X1

25X9 * In thanking the DDS for support of the project, the DDP indicated that [redacted] Support Directorate personnel were active in the project.25/

25X1



During the three-year period from the beginning of 1960 through 1962 there were a number of other developments that warrant recording.

B. Changes in Command and Organization

During this period there were many changes in senior personnel of the Agency. The Chief of the

Medical Staff, for example, was called upon to brief the new DCI-designate, John A. McCone, in October 1961 and the new DDCI, Lieutenant General Marshall S. Carter, in April 1962 on activities of the Medical Staff. There were also significant Agency organizational changes such as the creation of the position of Executive Director in April 1962 -- during the previous month Dr. Tietjen had appeared before the Agency Reorganization Committee, which was chaired by Lyman Kirkpatrick, who became the Executive Director. Within the Medical Staff there was also a major realignment of responsibilities. In December 1961 the Chief of the Medical Staff announced that the Chief of the Operations Division was relieved of responsibility for communications, overseas support, 25X1 liaison, and [redacted] in order that he might concentrate on operational activities. The Deputy Chief of the Medical Staff assumed direct responsibility for the first three of these functions, and the Support Division took over [redacted] 25X1

C. Operational Support

As part of the new Medical Staff emphasis on operational support, [redacted] who had completed Agency-sponsored residency training in psychiatry in 1961, was assigned in January 1962 directly to the Office of the Deputy Director for Plans to provide continuing professional advice in operational and personnel activities of the Clandestine Services. 25X1

Other developments in expanded operational sup- 25X1

[redacted]

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D. Field Support

As previously noted, in the late 1950's key personnel of the Medical Staff did considerable traveling in support of overseas operations. The Chief of the Medical Staff, as personal physician, had previously accompanied the DDCI and his party on overseas TDY's -- including an extensive round-the-world trip in November-December 1959. In January 1961 the Chief of the Medical Staff accompanied the DDS on a Far East Survey, and returned to the area again in October of that year to represent headquarters at the Annual Far East Medical Conference. In October 1961 the Chief of the Support Division made the initial survey of medical support for paramilitary activities in Southeast Asia, an effort that was to expand greatly later in the decade. This survey recommended the expanded and continuing use of medical supplies in Agency operations in Vietnam. It also recommended the assignment of an Agency medical service officer to Saigon to coordinate the provision of these supplies and to coordinate an expanded medical training program for

indigenous medical personnel.27/

25X1

[redacted]

E. Liaison

The liaison activities during this period were also extensive. In early 1961 there was a series of meetings with the newly appointed Medical Director of the Department of State. In 1962, planning for the release of the Cuban liberation fighters captured at the Bay of Pigs required frequent liaison with the US Public Health Service and with the Surgeon Generals of the military services. [redacted] and 25X1 Agency medical supply personnel later actually

worked in the Department of Justice to coordinate the collection of the medical supplies used as ransom for these liberation fighters.* Also in 1962, at the request of the Federal Aviation Agency, the Psychiatric Staff provided psychiatric screening for candidates for the FAA "goon squads" in one of the initial national efforts to counteract airplane hijackings.28/

F. Movement and Expansion

On 29 and 30 March 1962 the Medical Staff moved to the new Headquarters Building, its third and by far its finest home. In October of that year came the Cuban missile crisis, and the Medical Staff, with the rest of the Agency and the Government, assumed a tense DEFCON 3 position; medical personnel remained on alert for days while emergency plans and medical support procedures were readied and refined.

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* The story of these negotiations is given in detail in the Office of Security history Overseas Security Support, OS-7, April 1972, pp. 359-379, by [redacted] 25X1

25X1 [redacted]

A last, but by no means least, important development in this period was the transfer on 14 November 1962 of the Assessment and Evaluation (A&E) Staff from the Office of Training to the Medical Staff. 25X9 [redacted] their physical plant, and the appropriate portion of the OTR budget thus became part of the Medical Staff and the Medical Career Service. This was a decision reached by the DDS and senior management after months of study; it was based on the conclusion that a professional activity such as A&E psychological services would be more appropriately located as part of a larger professional component like the Medical Staff. Thus, through this transfer, two Agency elements -- the Assessment and Evaluation Staff and the Psychiatric Staff -- which on more than one occasion had engaged in jurisdictional dispute -- were now part of the same operating staff. Any future disputes would be "family fights."*

Of more importance in the longer range interest

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* Subsequent differences would reflect the normal professional differences of presentation expected of psychology and psychiatry.

of A&E, however, was the decision to keep its staff intact -- in effect, its own sub-career service -- and transfer it to the Medical Staff with its basic program unchanged. With its professional and organizational integrity assured, in the next decade the A&E Staff, as a part of the Medical Staff, was to have an impressive broadening of its charter; "assessment and evaluation" would no longer adequately describe the range of its varied services, and A&E became the Psychological Services Staff.

VI. The Sixties, 1962-70

A. Organization and Management

1. Organizational and Building Changes. Even before the new Headquarters Building was occupied the Agency knew that the building was not big enough. Some units would never move in; and some units, after moving in, would -- in the never-ending ways of bureaucracy -- move out. Thus in November 1963 the Assessment and Evaluation Staff of the Medical Staff moved to the [redacted] 25X1 [redacted] 25X1 Two months later they were joined by a newly established Medical Staff unit, [redacted] 25X1 25X1 [redacted] The Assessment and Evaluation

Staff remained at [redacted] until August 1971 when it moved to the adjacent [redacted] Building -- again another new building. The Dependent Medical Facility, however, remained at [redacted] only until December 1966 when it was moved to the [redacted] another new structure, in preparation for its subsequent integration with the Selection Processing Center in 1967. In October of 1967 all initial physical examinations -- pre-employment and entrance on duty -- were moved from the Headquarters Medical Facility to [redacted] as part of the general plan for making that area the "gateway" for all Agency personnel processing. In December 1968, after lengthy negotiation to obtain the appropriate personnel and funds, this medical activity was formally established as the Selection Processing Division of the Office of Medical Services -- the Medical Staff had been formally redesignated the Office of Medical Services in October 1964, with Dr. Tietjen assuming the title of Director of Medical Services.

25X1
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In 1964 there were three other internal organizational developments in the Office of Medical Services in addition to its change of name. For the first time there was a full-time Executive Officer, OMS; the Medical Career Board was reorganized into its present configuration of a Board with three subsidiary panels representing physicians, psychologists, and medical administrative/technician personnel; and the first of the OMS consultant panels was established. This was the Psychiatric Consultant Panel, which assembled for the first time in March 1965. The purpose of the panel was to review the Agency's psychiatric program on a continuing basis to assure that it remained professionally current in its field. In 1966 an analogous Psychological Consultant Panel was established to assure the professional currency of the Agency psychological services effort. The third panel, the Clinical Consultant Panel, had its initial

meeting in February 1970.*

In April 1965, with the expert advice of a consultant interior decorator the Agency had retained, the grey face that came with the new OMS quarters in 1962 was lifted. The OMS facility became a multi-colored suite with varying red, yellow, and orange doors and other appointments, redecorated in the same manner as the rest of the Headquarters Building.

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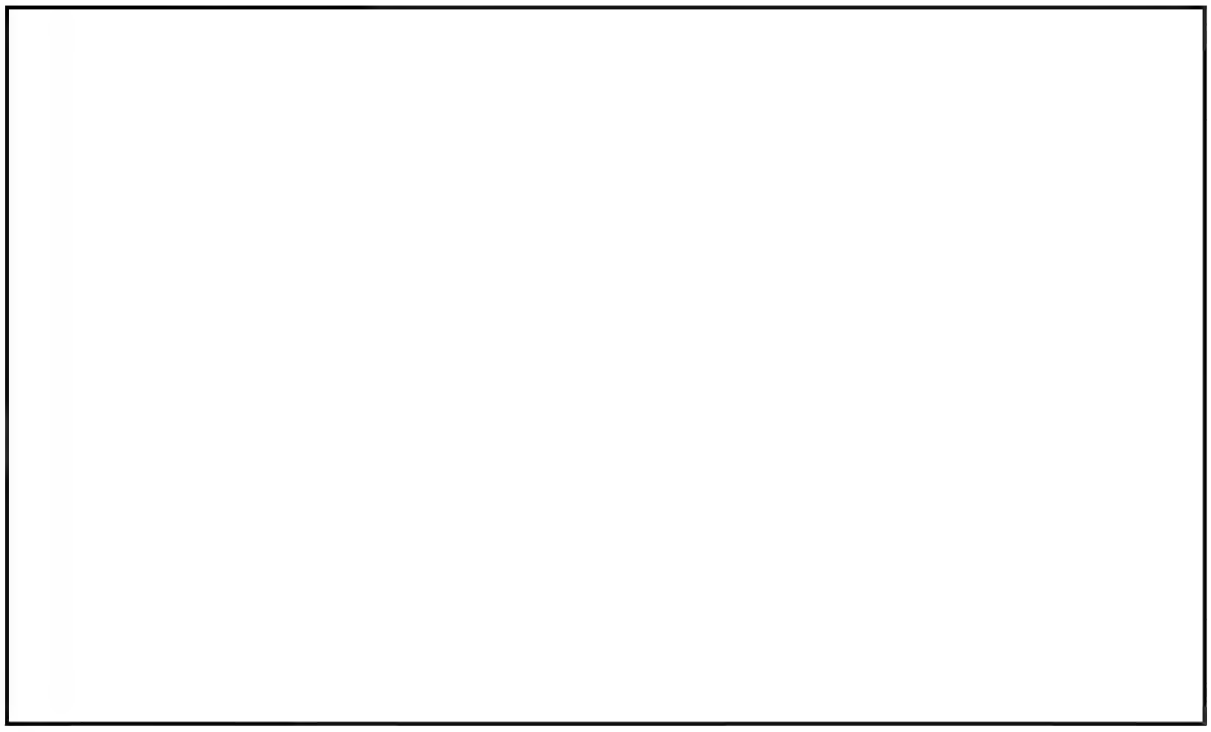

A noteworthy personnel development of the decade was the fact that three senior medical officers who resigned during the period to enter private or industrial medicine chose, after only a matter of months, to return to the Agency as careerists. Each reported that private practice, despite the greater remuneration, did not provide certain satisfactions that work in the Agency did.

3. Programs and Procedures. At a DDS staff meeting in January 1966 a representative of the Office of Planning, Programming, and Budgeting told about the new requirement -- the "Combined Program Call" by which the Agency would thereafter conduct its planning and budgeting. There had been some previous long-range planning; in 1965, at the direction of the DCI, each operating official had submitted a 5-10-15 year plan.* This had been accomplished on a task-force basis, but

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* OMS long-range plan featured the following: 1966-70: Conservation of manpower, Management assistance, Operational support, and Improved field support. 1971-75: Automation. 1976-80: Medical program of the Intelligence Community.

now it was to be an annual requirement.

The first OMS plan under this new procedure was submitted in March 1966 to cover the FY 1968-72 period.29/ This plan projected ten goals for the period:

a. Field Support Program -- augmentation

b. Selection Processing Center -- establishment

c. Improved Diagnostic Procedures

d. Annual and Executive Examination Program -- expansion

e. Professional Development -- establishment of professional consultant panels

f. Automation of Medical Records

g. Counseling Service -- expansion

h. Special Studies Program -- management, personality, operational

i. Direct Operational Support -- expansion

j. Behavioral Aspects of Human Resources -- assistance to management through a multi-discipline approach to human resources.

Most of these goals continue to be relevant to this day (1972).

In 1965 the OMS Clinical Review Board (CRB) first met. Its purpose was to conduct a total OMS review

of certain medical evaluations before OMS disposition to insure that all aspects of a case -- clinical, psychiatric, and administrative -- had been considered. The CRB was an immediate success and remains active to the present.

Also in 1965 the first Board of Medical Examiners (BME) under the new CIA Retirement and Disability System convened. The BME continues to be effective to this day. The value of another kind of board convened for a special purpose is illustrated by the special OMS board that met in September 1965 to review the case of a chief of station [redacted] 25X1 [redacted] 25X1 Through careful gathering of data, including a visit to the hospital by an Agency medical officer, the board established that the facilities and standards at the hospital were sufficiently below those found in US hospitals that the case appropriately should fall within the purview of the Employees' Compensation Act. As the result of the work of the OMS board and the resulting Agency recommendation to the Bureau of Employees' Compensation, the monthly compensation to the COS's

widow was increased 88 percent over what it would have been without the board's findings.

4. The Inspector General's Survey. In September 1967 the D/MS met with the Inspector General and the IG team that was to conduct the routine periodic IG survey of the OMS; the last one had been conducted in 1955. The team completed its survey in June 1968. Its report of the survey was summarized as follows:

> The Director of Medical Services has developed one of the finest civilian medical programs in the Federal Government. It is a high-quality program, designed to be responsive to the specialized needs of the Agency. It has made a very impressive contribution to the morale and spirit of the organization.*30/

Although not connected with the IG survey, there was conducted in February 1968 what amounted to a professional audit of the OMS. John McCone, the former DCI, had written to Richard Helms, then the

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* Among the several specific recommendations of the IG survey report was one that the title of the Assessment and Evaluation Staff be changed to the more appropriate Psychological Services Staff. Thus in July 1969, A&E became PSS.

DCI, recommending that a [redacted] 25X1
25X1 [redacted] be considered by the Agency for any occasional medical requirement the Agency might have. The Director of Medical Services was consulted and, on the basis of his confirmation of 25X1 [redacted] outstanding reputation as an internist, the Executive Director-Comptroller requested 25X1 [redacted] to conduct a survey of the OMS clinical activity. This he did in January and February 1968. In a verbal report to the Executive Director-Comptroller he gave his unqualified endorsement to the OMS program.*31/

B. New Programs

1. Clinical. In 1963 the Chief of the Clinical 25X1 Division, [redacted] at the time, presented a major plan for a bioelectronics program in the Agency.32/ This involved primarily the introduction of advanced electronic procedures in the diagnostic

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25X1 * [redacted] was retained as a consultant until 1969 when he retired.

activities of the Clinical Division.* It also proposed the extension of these procedures to the Office of Security in a joint effort involving the polygraph and the recording of certain physiological data. The Office of Communications was to have a major support role, and officials of the Research Directorate, such as Dr. Albert D. Wheelon, were consulted. The plan was presented to the DCI in a formal briefing, but approval was not forthcoming -- undoubtedly because of the size of the funds proposed. Seven additional staff members and $204,968 were requested for the first year; a total of $1,677,413 and ten staff employees were requested for the proposed four-year duration of the project.

The idea did not die, however. In 1967 a new Chief of the Clinical Division, [redacted] 25X1

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* For example, laboratory procedures would be automated by the introduction of an automatic analyzer that would provide several standard test procedures on several blood specimens at a time -- procedures that were being done by technicians on a case-by-case basis; electrocardiograms would be more sophisticated; and certain additional tests such as pulmonary capacity tests would be introduced.

25X1 [redacted], approached the matter in a more modest fashion by first visiting the George Washington University Medical Center, where certain innovations were being made in the use of computerized electrocardiography. From this evolved a continuing low-keyed Clinical Division effort of an applied research nature, using existing resources. In 1970, upon his return from two years of Agency-sponsored residency

25X1 training, [redacted] was appointed to the new position of OMS Medical Systems Development Officer, with the responsibility for developing such programs. The Multiphasic Screening, Periodic Health Evaluation, and Information Processing System Program (MPS/PHE/IPS) proposed for FY 1973 in the OMS Program Submission of March 1971 was, in a sense, the sequel to these various earlier efforts. This program is described further in Section VII below.

The MPS/PHE/IPS program is, however, only a means to an end -- the "Conservation of Agency Manpower." This latter concept was initially proposed by Dr. Tietjen at an OMS staff meeting in June 1965. He pointed out that since its beginning the Agency had,

for good reasons, given primary attention to the selection of personnel; perhaps the time had come to give more attention to the health of personnel already on duty. Dr. Tietjen followed this up in August 1965 with a paper, "Medical Views on Planning and Human Resources." This think-piece written for Agency senior management called for no specific action but did signal a major change in emphasis in the Agency medical program, one that prevails to this day. This change in direction of effort was facilitated by the coincidental issuance in June 1965 of a Bureau of the Budget directive that expanded the scope of health service programs for Federal Employees.33/ Although the directive made no great change in the existing Agency health service program, it did give official sanction for the provision of certain services that were already being provided.*

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* Even as this history was being completed (October 1972) announcement was made [redacted] 10 Aug 72) of OMS' Health Education Program, and the first in a series of quarterly Medical Newsletters in support of that program was issued (September 1972). 25X1

2. Management Assistance. In the early 1960's the specter of alcoholism loomed as an element in the evaluation of several Agency officials who were nearing retirement. Although its incidence in the Agency was small, in 1965 the Director of Medical Services established an OMS Committee on Alcoholism. The purpose of the committee, made up of the chiefs of the professional OMS divisions, was to study the problem and submit recommendations for action. The committee met periodically through 1969. Some results of its study and recommendations were:

a. In March 1967 the Chief of the Psychiatric Staff and the Chief of the Psychological Services Staff presented to the Operations Familiarization Course the first formal lectures on Alcoholism.

b. In May 1968 Dr. Tietjen and other OMS officials made a similar but expanded presentation to senior officials of the Offices of Personnel, Security, and Training.

c. In 1968 the Director of Medical Services proposed an Alcoholism Program for the Agency as suggested for all Federal agencies by the Chairman of the Civil Service Commission. Agency management chose, however, to defer such a program. In 1972, in the wake of the enactment of Public Law 91-616 requiring a program in each agency, such a program has been inaugurated by the Agency and a DCI statement of Agency policy on problem drinking has been issued, essentially as drafted by the OMS in 1968.

The present wide spectrum of new forms of management assistance being provided by the Psychological Services Staff had its origin in a paper on "feedback" to management that OMS submitted to the DCI's ad hoc Planning Group in September 1965. The basic problem was the provision to management of data about the attitudes, personal satisfactions and dissatisfactions, and aspirations of personnel -- data that management was not getting in a systematic way. Such information would, of course, enable management to improve organizational effectiveness. The first major study of the feed-back problem itself was a 1966 PSS survey of the attitudes of career trainees.34/ In 1970 the Inspector General requested the help of PSS in responding to a Government-wide inquiry concerning youth in the Federal Government. The resulting PSS survey of Agency professionals was presented by PSS psychologists in a formal briefing of the DDCI. The chief of PSS now (1972) chairs a DDS group that has proposed a similar survey of all Agency human resources.

In 1968 PSS assistance in counseling employees

preparing for retirement was requested by the Office of Personnel. For this and other counseling activities a Counseling Center was established in PSS. Expansion of this kind of service by PSS and other OMS elements resulted in the formal establishment in 1969 of an OMS Consultative Services Program.35/ Under this program an employee -- and his supervisor if he wishes -- may get professional counseling on a job-related problem. The employee may also get consultative help on a personal or family problem of health or adjustment. Emphasis is placed on ease and promptness in getting an appointment -- without the procedural machinery of formal request.

In 1966 the OMS Support Division devised a means for providing the Clandestine Services with periodic indications of the medical assignability of its personnel. This procedure, which makes use of code letters to indicate the readiness of an employee and his dependents for overseas assignment, was extended in 1967 to cover Office of Communications personnel.

Finally, in the area of new concepts in management assistance, in 1969 OMS completed arrangements

for a "Medical Assistance Group" of experienced medical technicians and medical service officers who would be prepared on a 24-hour basis to provide on-the-spot para-medical assistance to Agency components in the Washington area, particularly to the Office of Security Emergency Force.

3. Operational Support. In a 1964 survey of the Clandestine Services the Inspector General recommended that OMS conduct a research project on

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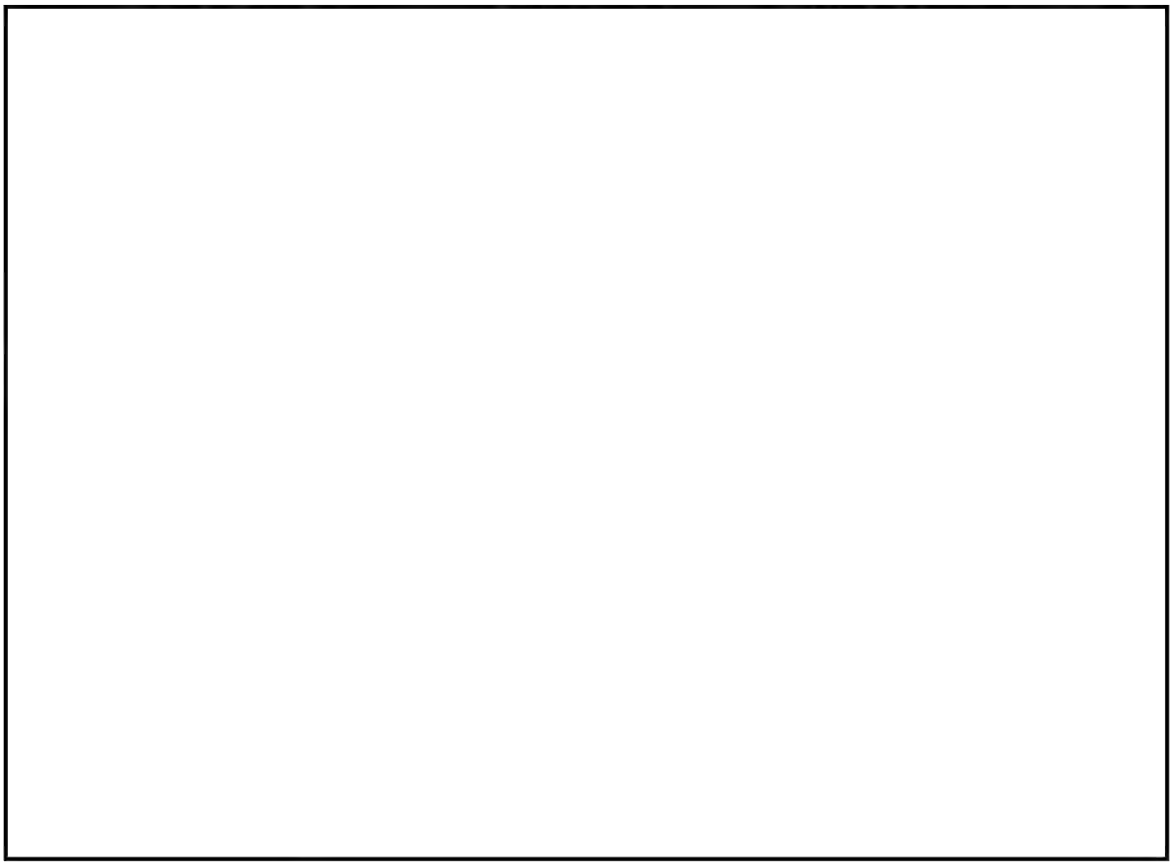

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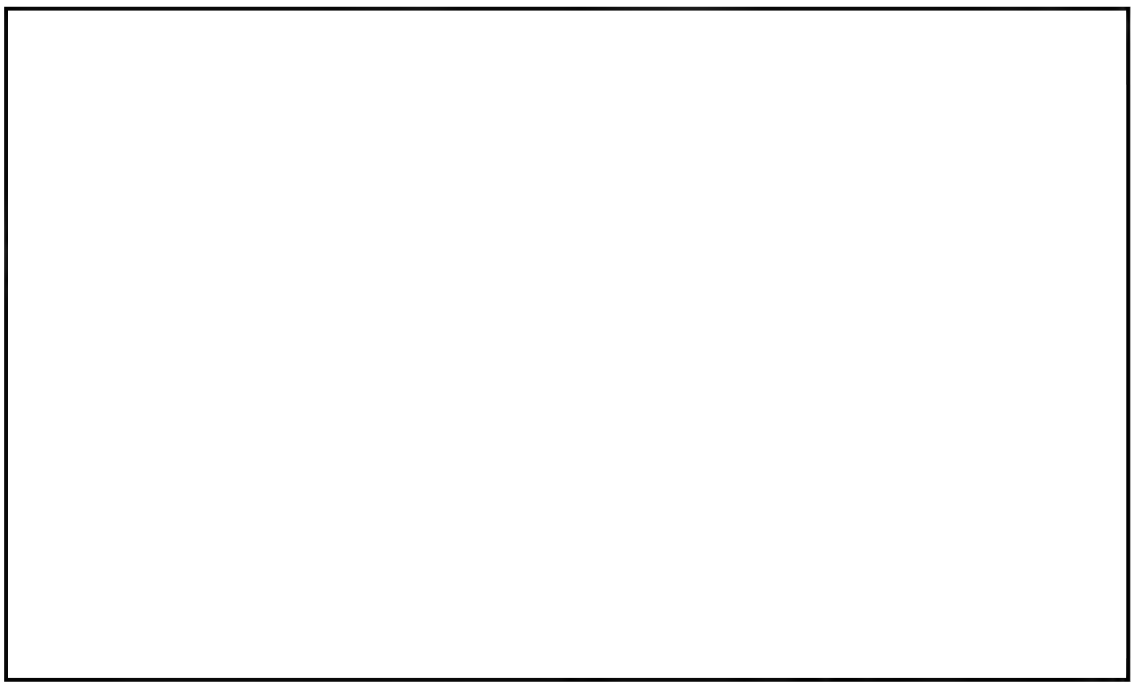

It was one of the specific recommendations of the IG's 1967-68 survey of the OMS that special efforts be made to apprise the Clandestine Services of OMS support capabilities. Accordingly, starting in late 1968 with the Foreign Intelligence (FI) Staff, a series of such briefings was conducted by an OMS briefing team. According to the OMS personnel involved -- members of the Psychiatric Staff, the Psychological Services Staff, and the Operations Division -- many Clandestine Services personnel who attended the briefings were apparently unaware of the scope of available medical support. The OMS

officers felt that the briefings resulted in closer working relationships with DDP operational officers.

4. The Drug Abuse Program. The most recent program of note is that designed by the Operations Division to assist Agency personnel and their dependents to understand and avoid the misuse of drugs. The drug problem has never been a serious one among Agency employees; the program was initiated largely as a preventive measure. It emanated from OMS discussions in 1970 with the Office of Security; Office of Personnel and Office of Training officials later joined these discussions. The program features an elaborate exhibit, which has been displayed at the Headquarters Building and at other Agency installations, and lectures by OMS professional personnel. In June 1972 the exhibit was displayed at the Annual Convention of the American Medical Association in San Francisco. This was a departure from traditional low-profile practices in Agency medical affairs and required the sanction of the DCI. To the great delight of the OMS, and the DCI as well, the Agency's exhibit was awarded first prize in its class of

exhibits. This was the Billings Gold Medal for teaching exhibits.

C. Expanding Medical Support

An especially interesting feature of OMS history in the 1960's was the significant increase in the frequency of requests to OMS from other agencies for advice or assistance. Examples of some of these requests, by agency and general type of assistance requested, are:

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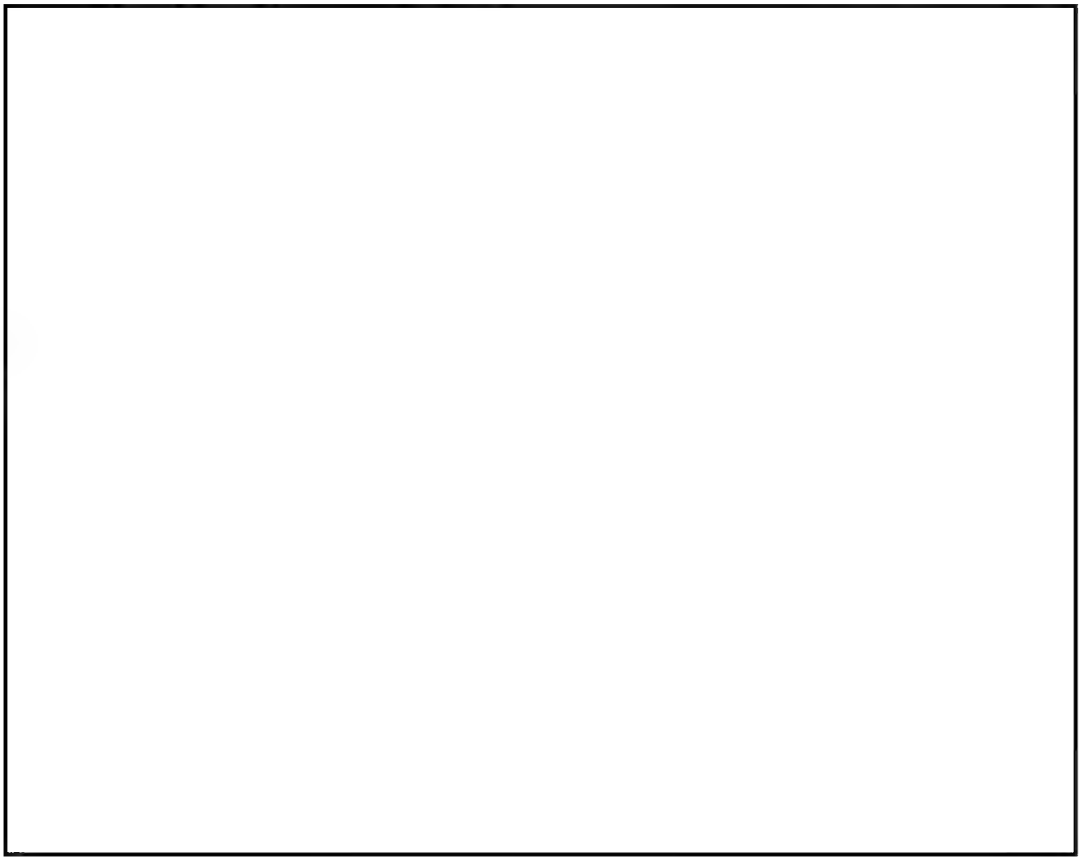

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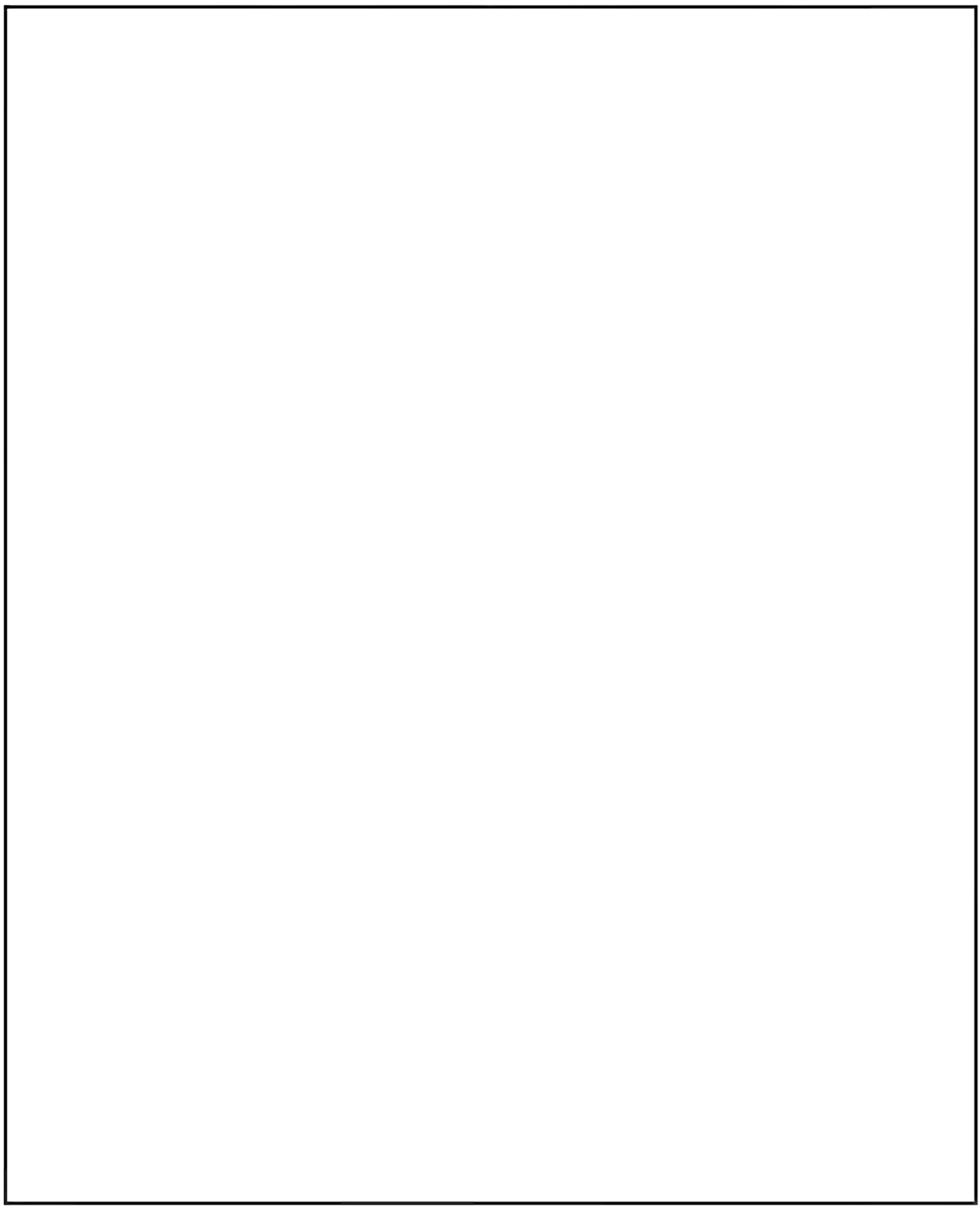

was to reflect this wider spectrum of services that its name was changed in 1969. It was particularly gratifying to the OMS that this wider recognition, more frequent use, and generally enhanced professional reputation of the PSS should follow its incorporation into the OMS.

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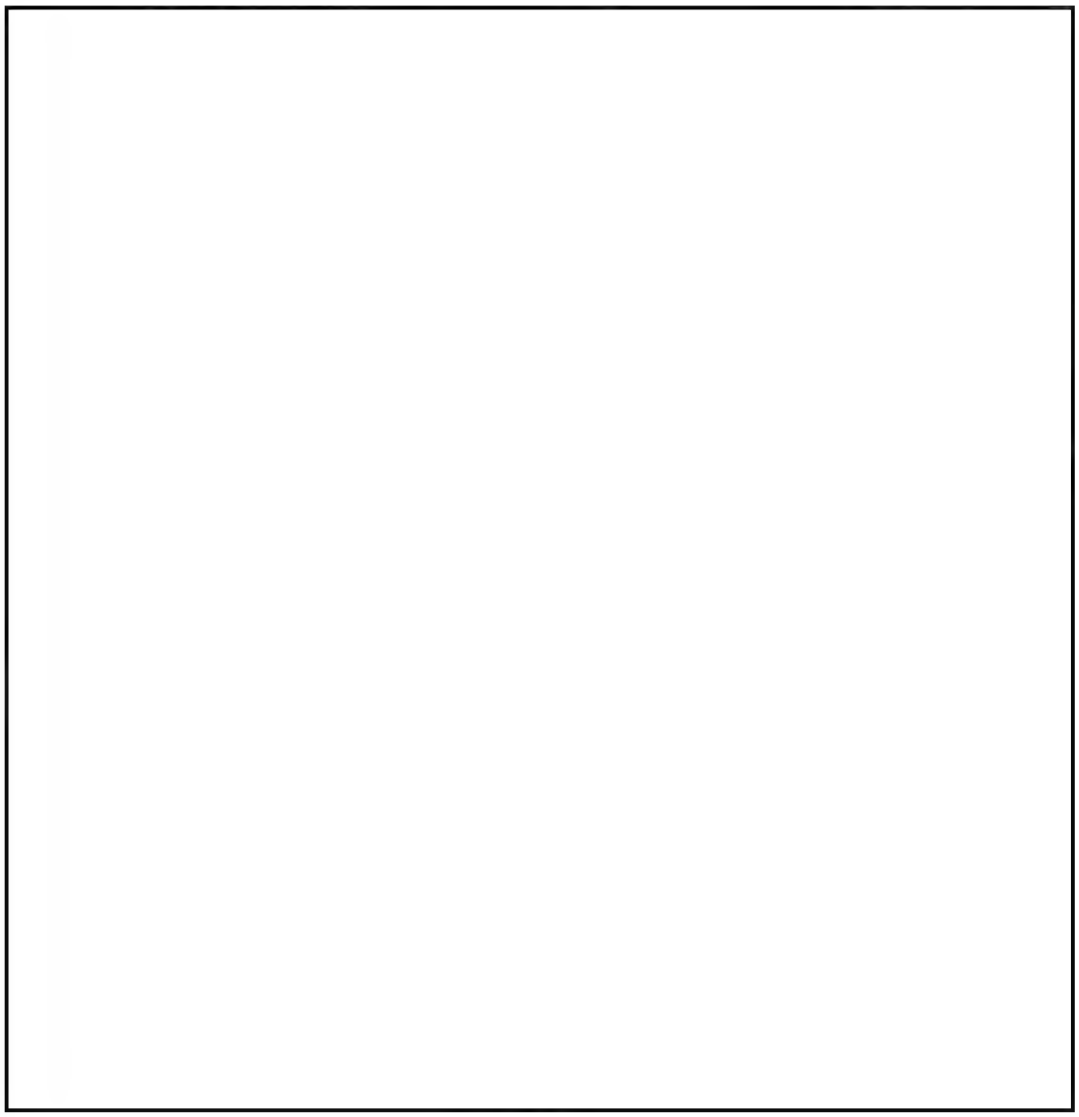

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VII. Conclusion and Projection

A. Conclusion

The Agency medical program is now a quarter of a century old. It has served the Agency through two wars, six DCI's, numerous contingencies, and countless personal health crises of employees who have grown old and worn in service and a few others -- very few, in fact -- who have worn out before their time. Each one of the thousands of people who worked in the Agency during this period passed through the OMS at some time in his career. It has been an impressive cavalcade, a rich and rewarding but humbling experience.

What can be said in a summary way about the program? Perhaps the Inspector General said it best in the summary statement of his 1968 report of survey already quoted.*

As much as any program in the Agency's experience, the medical program has been the work of one man.

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* P. 70, above.

John Tietjen has been the only D/MS. He conceived the program, nurtured it through its long years of growth, and brought it to its present maturation. For most of this long journey there was no chart, no guidebook, no SOP; most of the things that had to be done in running a new medical program in a new intelligence service were being done for the first time. The book was being written.

The problems over this quarter of a century were many and varied. Not the least of these was the great and almost constant turnover of professional personnel -- a problem not uncommon to an organizational medical program in Government or industry. Another problem of great moment was, and is, that of ensuring the confidentiality of personal medical information -- always a problem for an organizational medical service in its dual role as guardian of the health of employees and advisor to management. Although the Agency medical program has been remarkably free of allegations of invasion of privacy, the danger has always been present. The success of the OMS Consultative Services Program since its inauguration

in 1969 would seem to indicate that an effective balance has been achieved in the competing demands of the guardian-adviser role. In an era of great sensitivity to threat of invasion of privacy, however, maintenance of the confidentiality of personal medical data -- particularly in an intelligence organization -- must be a matter for continuing vigilance. But if the problems have been great, the rewards have also been great. Not the least of these has been the abiding satisfaction and sense of fulfillment in serving the people of the Agency.

B. Projection

If what is past is prologue, the OMS is heartened. But what is past is also gone, and the accomplishments of yesterday are of limited value in solving the problems of today. The hallmark of modern medicine and psychology is change, accelerating change. It must be the major goal of OMS to assure that the advances in medicine and psychology are integrated into the Agency medical program. Two major areas of application will receive particular attention in the immediate future: multi-

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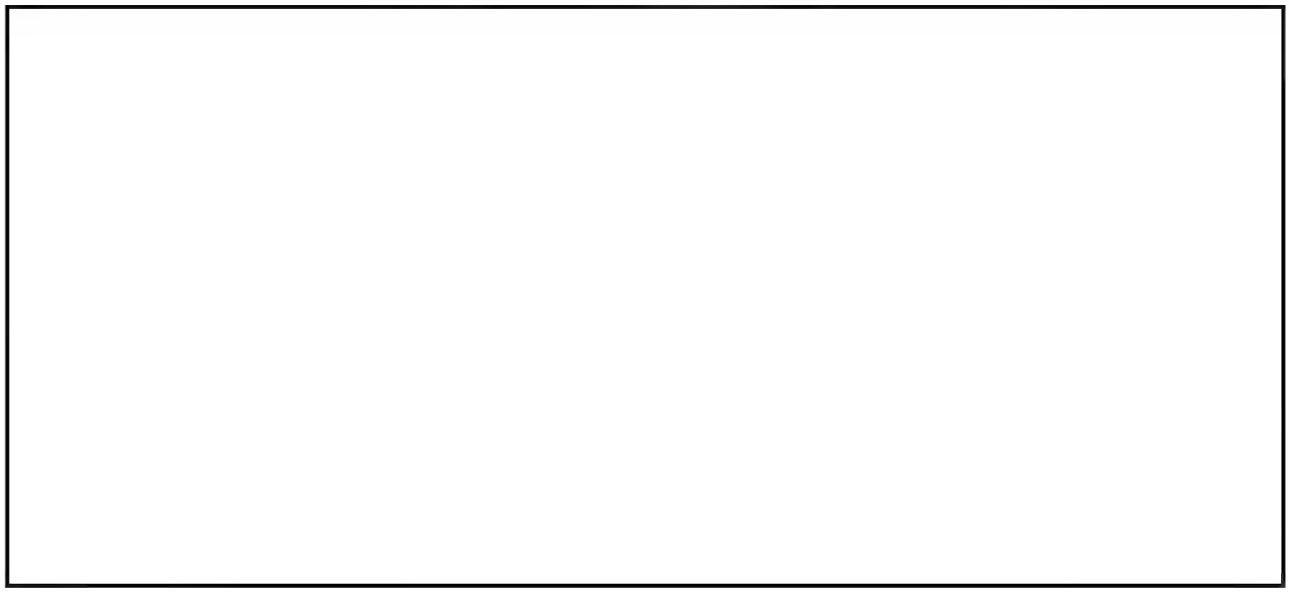

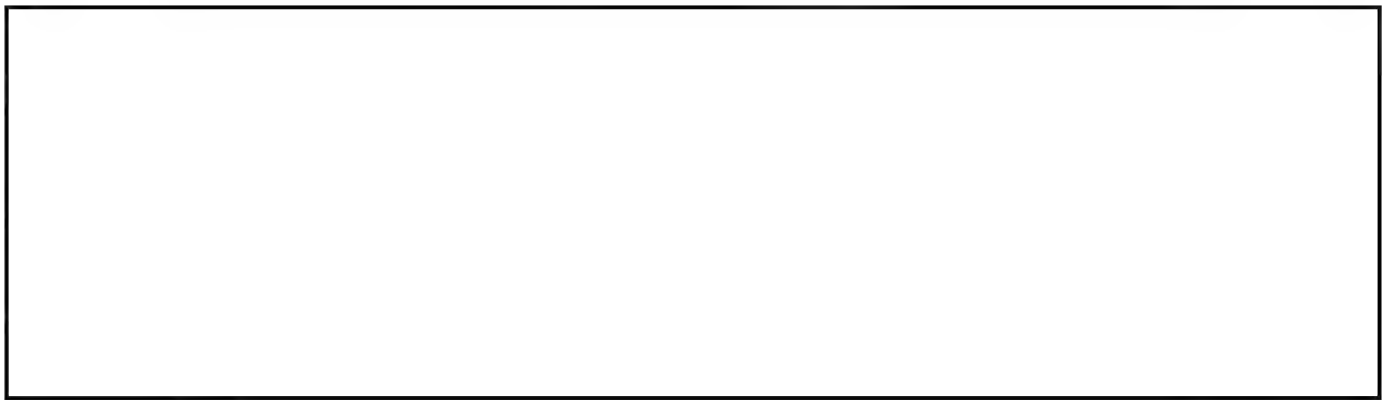

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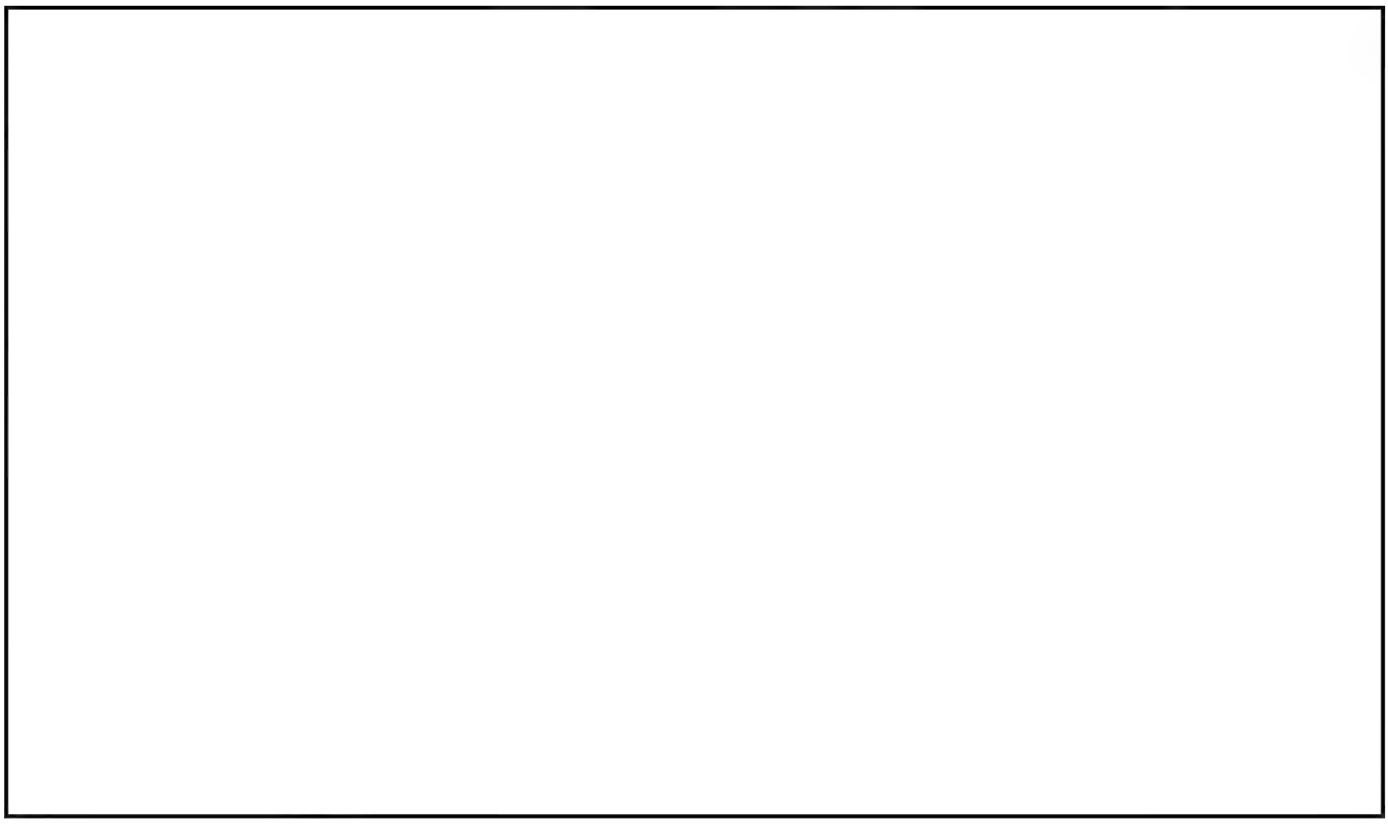

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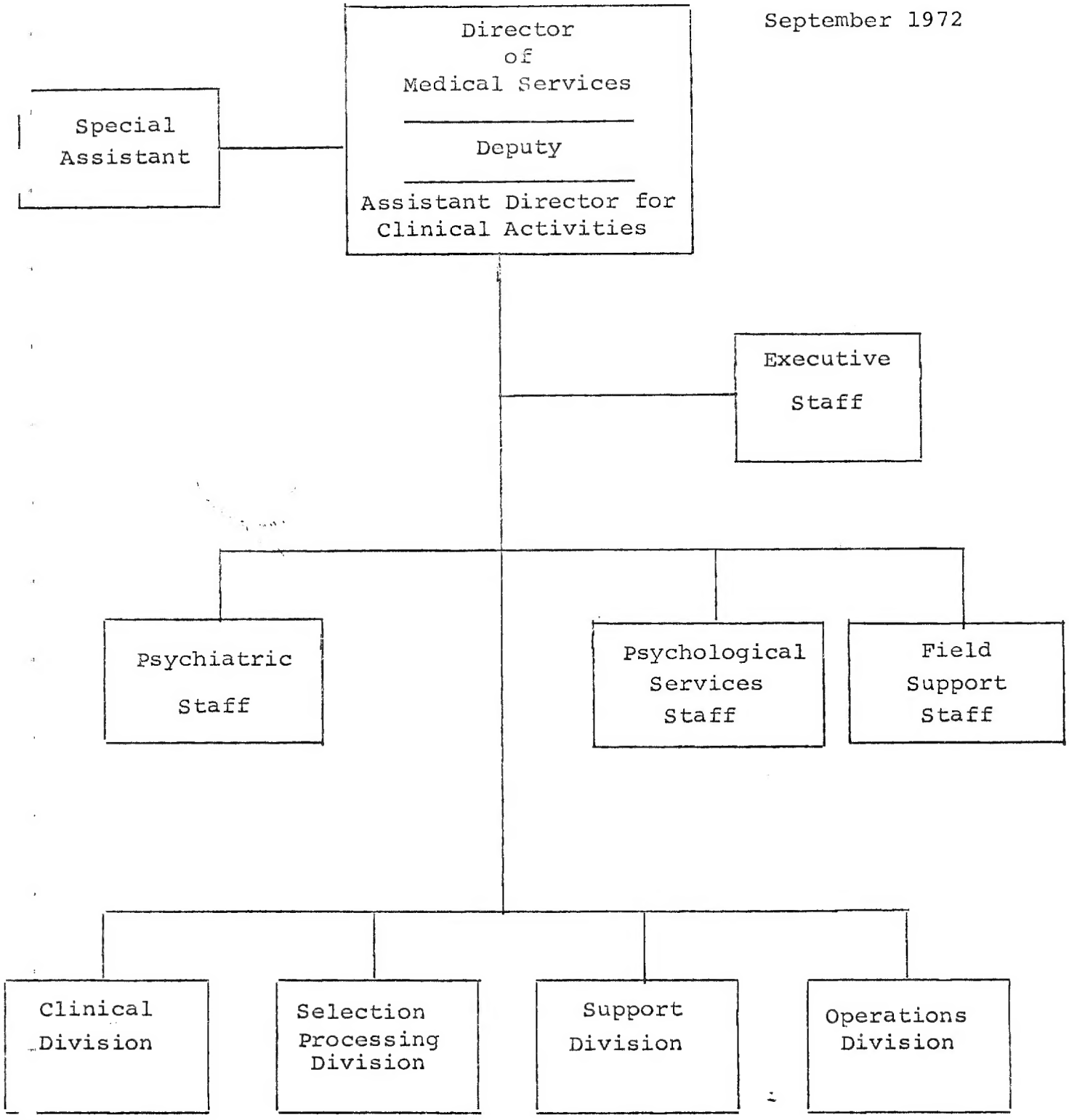
Appendix E

OFFICE OF MEDICAL SERVICES ORGANIZATIONAL CHART

September 1972



Appendix F

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